The Deficit Reduction Act:
Important Facts for State Government Officials

The Deficit Reduction Act (DRA) provides States with much of the flexibility they have been seeking over the years to make significant reforms to their Medicaid Programs. States may use these new opportunities in combination with other options under the Medicaid Program, State Children's Health Insurance Program (SCHIP) and other programs as a strategy to align the Medicaid Program with today's health care environment. States can expand access to affordable mainstream coverage, promote personal responsibility for health and accessing health care, and improve quality and coordination of care. The DRA provides flexibilities that States can use to pursue innovative ideas in health care—like consumer-directed healthcare and rebalancing long-term care.

This publication contains brief descriptions and a checklist for many of the provisions contained in the DRA. The publication will help State government officials in implementing the DRA. For more information, see **www.cms.hhs.gov/deficitreductionact** on the web.

NEW OPTIONS FOR BENEFIT PACKAGES

Under Section 6044, the DRA provides States with the flexibility to change their Medicaid benefit packages to mirror certain commercial insurance packages through the use of benchmark plans. States may use this authority to leverage employer-sponsored coverage of Medicaid beneficiaries. While only certain groups of beneficiaries may be mandated into a benchmark benefit plan, States may also use this flexibility to provide tailored benefits to meet the special health needs of other groups of beneficiaries on a voluntary basis. Within these packages, States have the option to amend their State Medicaid Plan to provide State flexibility in benefit packages without regard to traditional requirements such as statewideness, comparability, freedom of choice, or certain other traditional Medicaid requirements.

NEW OPTIONS FOR PREMIUM & COST SHARING

Sections 6041 and 6042 of the DRA allow States to vary the premiums and cost-sharing that they charge to certain Medicaid recipients. No premiums are permitted for families with income above 100 percent and at/or below 150 percent of the Federal Poverty Limit (FPL). Cost-sharing up to 10 percent of the cost of services is permitted within this group. Above 150 percent of the FPL, premiums are permitted and cost-sharing up to 20 percent of the cost of services is allowed. No premiums or cost-sharing are permitted for families with incomes below 100 percent of the FPL. The DRA contains special rules on cost-sharing for prescription drugs and non-emergency care provided in emergency rooms (ER).

In addition, States have the option to require payment of alternative premiums as a condition of eligibility and alternative cost-sharing as a condition of receipt of the service or drug, or cost-sharing for non-emergency services in the ER. The DRA provides that the aggregate premium and/or cost-sharing amounts must not exceed 5 percent of the family's income for all family members for the month or quarter period. As part of the ER provision, the DRA sets up a grant program that provides $50 million in funding over 4 years for States to establish non-emergency alternate providers.

REBALANCING LONG TERM CARE

Money Follows the Person (MFP)

This demonstration, established by section 6071 of the DRA, supports State efforts to "rebalance" their long-term care (LTC) support systems by offering $1.75 billion over 5 years in competitive grants to States. Under this DRA provision, States are able to make targeted reforms to strengthen the community-based infrastructure so that individuals have a choice of where they live and receive services. These grants encourage States to adopt a strategic approach to improving quality in both home and community-based services and institutional settings as the State designs and implement its rebalancing initiative. In July 2006, CMS solicited proposals from States to participate in the Money Follows the Person Rebalancing Demonstration (MFP Demo). The grant proposals were due November 1, 2006 and are currently being evaluated by CMS. Monitor the CMS website at **www.cms.hhs.gov/newfreedominitiative** for updates on the grant awards.

Long Term Care (LTC) Partnership

The LTC partnership is a unique program combining private LTC insurance and special access to Medicaid. The partnership helps individuals financially prepare for the possibility of needing nursing home care, home-based care or assisted living services sometime in the future. The program allows individuals to protect some or all of their assets and still qualify for Medicaid if their LTC needs extend beyond the period covered by their private insurance policy. Section 6021 of the DRA allows for Qualified State Long-Term Care Partnerships. States with approved State Plan Amendments (SPAs) also exclude from estate recovery the amount of LTC benefits paid under a qualified LTC insurance policy.

Transfer of Assets

The cost of LTC continues to increase, making such services difficult to afford for most individuals, and inaccessible for many. The Medicaid Program provides coverage of LTC services for individuals who are unable to afford this care. Some individuals, with assistance from financial planners and attorneys, have developed methods of arranging assets in such a way that they are not countable when Medicaid eligibility is determined, and are thus preserved for the individual and/or family members. Various techniques are used to artificially impoverish Medicaid applicants, including gifting of assets to family members, investing assets in financial instruments that are inaccessible, and executing financial transactions for which fair market value are not actually received to get LTC coverage through Medicaid. Sections 6011 through 6016 of the DRA include several provisions designed to discourage the use of such "Medicaid planning" techniques and to impose penalties on transactions which are intended to protect wealth while enabling access to public benefits.

DOCUMENTATION OF CITIZENSHIP

Section 6036 of the DRA requires States to obtain satisfactory documentary evidence of an applicant's or recipient's citizenship and identity in order to receive Federal Financial Participation (FFP). Effective July 1, 2006, individuals must provide satisfactory documentary evidence of citizenship and identity when initially applying for Medicaid or upon a recipient's first Medicaid re-determination. The statute and interim final regulation provide States with guidance on acceptable documentary evidence, including alternative forms not explicitly named in statute. The statute and regulation also give States guidance on the processes that may be used to minimize the administrative burden on States, applicants, and recipients. CMS encourages States to utilize automated matching systems to verify citizenship and identity in order to satisfy these requirements.

CONSUMER DIRECTED HEALTHCARE
Health Opportunity Accounts

Section 6082 of the DRA allows for ten States to operate Medicaid demonstration programs to test alternative systems to deliver Medicaid benefits through a Health Opportunity Account (HOA) in combination with a high deductible health plan (HDHP). The demonstrations will provide States with the option of allowing individuals to assume greater responsibility for their own care by enrolling in flexible consumer-based accounts. Recipients are given the tools to take a greater role and responsibility in their health care. States can adjust contributions to the accounts based on the expected health needs of recipients, to ensure that the HOA program works well both for healthier recipients and those with chronic illnesses. More information about the HOAs will be distributed soon.

HOME & COMMUNITY BASED SERVICES

The Home and Community-Based Services (HCBS) waiver program in particular is a viable option for States to use to provide integrated community-based long-term care services and supports to qualified Medicaid eligible recipients. States can provide individualized, person-centered care through this model of care. As a result of the passage of the DRA, States can now amend their State plans to offer HCBS as a State plan optional benefit. This benefit allows States to provide most of the services now covered under HCBS waivers, with the exception of the services categorized as “other services”. States have advocated for the ability to provide HCBS services without needing to go through the waiver process for years. Now, the new DRA option breaks the “eligibility link” between HCBS and institutional care

A CHECKLIST FOR STATE LEGISLATORS ON THE DEFICIT REDUCTION ACT

NEW OPTIONS FOR BENEFIT PACKAGES

- ✓ **Does your State want to redesign its Medicaid benefits?**
  - ❑ If so, can your State use alternative benefit packages to update its Medicaid program?
- ✓ **Is your State interested in consumer-directed healthcare?**
  - ❑ If so, can your State use alternative benefit packages to implement consumer-directed healthcare?
- ✓ **Are legislative changes needed to the Medicaid program to implement new benefit packages?**
  - ❑ Changes to eligibility?
  - ❑ Changes to benefits?
  - ❑ Changes to services?
  - ❑ Changes to delivery system?
- ✓ **Does your State have an 1115 demonstration or other waiver program like a 1915(b) or 1915(c)?**
  - ❑ If yes, will a new amendment to the State Medicaid Plan be necessary to align with benchmark plans?

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NEW OPTIONS FOR PREMIUM & COST SHARING

- ✓ **Does your State want to redesign its Medicaid cost-sharing and/or its premiums?**
  - ❑ If so, can your State use the new options for premiums & cost sharing to impose alternative premiums and cost sharing upon certain Medicaid recipients?
  - ❑ Does your State require legislative changes to implement alternative premiums and/or cost sharing?
  - ❑ Does your State want to impose cost-sharing for the use of non-emergency services in the ER?

REBALANCING LONG TERM CARE

- ✓ **Does your State already participate in the long-term care partnership?**
- ✓ **If not, does your State want to encourage its residents to proactively plan for their long-term care?**
  - ❑ If so, consider participating in the long-term care partnership with insurers and the insured.
- ✓ **Does your State need to establish a workgroup including the State legislators, State Medicaid Director, State Insurance Commissioner, State Budget officer, regarding the Partnership?**
- ✓ **Does your State need to establish a workgroup with State health policy officials, insurers, advocates, consumers and other interest groups to establish procedural and policy guidelines that are consistent with the DRA, State law and NAIC rules?**
- ✓ **If your State wants to participate in the long-term care partnership,**
  - ❑ Does your State have an approved State Plan Amendment (SPA) to exclude in the eligibility determination and estate recovery, the amount of long term care benefits paid under a qualified long term care insurance policy?
  - ❑ If your State does not have an approved SPA, your State Medicaid agency must submit a SPA that specifies that benefits paid under a qualified long term care insurance policy will be disregarded in both the eligibility determination and in the estate recovery process.

A CHECKLIST FOR STATE LEGISLATORS ON THE DEFICIT REDUCTION ACT

TRANSFER OF ASSETS

- ✓ **Mandatory: Has your State Medicaid agency submitted a State Plan Amendment (SPA) that will apply the new transfer of assets rules and home equity cap that are effective February 8, 2006?**
- ✓ **Has your State altered the application for Medicaid coverage of long-term care expenses to include a disclosure of annuities and language which names the State as a remainder beneficiary?**
- ✓ **Does your State require legislative changes to apply transfer of assets policy to:**
  - ❑ Treatment of loans?
  - ❑ Promissory notes?
  - ❑ Mortgages?
  - ❑ Life estates?
  - ❑ Annuities?
- ✓ **Has your State implemented the undue hardship provisions mandated by the DRA that allow for the waiver of a penalty period?**

DOCUMENTATION OF CITIZENSHIP

- ✓ **Mandatory: Does your State need legislative changes to the Medicaid eligibility laws necessary to implement the new documentation of citizenship requirements?**
- ✓ **Will your State perform outreach to beneficiaries informing them of the new requirements?**
- ✓ **Is your State Medicaid Agency providing training on the new rules to eligibility workers?**
- ✓ **Has your State pursued using data matches to confirm eligibility and reduce costs?**

CONSUMER DIRECTED HEALTHCARE—HEALTH OPPORTUNITY ACCOUNTS

- ✓ **Does your State want to pursue consumer-directed healthcare?**
  - ❑ If so, consider participating in the 10 State demonstration program sponsored by CMS scheduled to begin January 1, 2007.
- ✓ **Are legislative changes needed to the Medicaid program to implement Health Opportunity Accounts?**
- ✓ **Does your State Medicaid program need to apply for an 1115 waiver or State Plan amendment to implement HOAs?**
- ✓ **Will your State do outreach informing beneficiaries of the new options?**

HOME & COMMUNITY BASED SERVICES

- ✓ **Does your State wish to use State plan amendments rather than waivers to provide long-term care services to certain populations?**
  - ❑ If so, consider the new home & community based services option.
- ✓ **Does your State want to move away from providing services through institutions by exploring the new Home & Community Based Services option?**
  - ❑ If so, what populations might be served (States can go up to 150% FPL)?